House of Representatives Study Committee on Retrospective Emergency Room Policies

Final Report

Chairman David Knight
Representative, 130th District

The Honorable Matt Hatchett
Representative, 150th District

The Honorable Lee Hawkins
Representative, 27th District

The Honorable Chuck Efstration
Representative, 104th District

The Honorable James Beverly
Representative, 143rd District

December 28, 2018
Prepared by the House Budget and Research Office

Introduction

The Georgia House of Representatives created the House Study Committee on Retrospective Emergency Room Policies (hereinafter "the committee") during the 2018 General Session through the passage of House Resolution 1194 following concerns raised by providers and patients regarding Blue Cross Blue Shield's retroactive emergency room policy implemented in 2017. Finding that these policies can dissuade patients from seeking needed care, contribute to medical debt, discriminate against patients with lower health literacy, and conflict with goals for access to care across the state, the committee was formed to evaluate the issues relating to retrospective payment policies for emergency care in Georgia and to publish its findings with recommendations.

Representative David Knight (130th) chaired the committee, which also included four additional House members: Representative Matt Hatchett (150th); Representative Lee Hawkins (27th); Representative Chuck Efstration (104th); and Representative James Beverly (143rd). The House Budget and Research Office assigned Mr. Leonel Chancey to assist the committee, while the Office of Legislative Counsel assigned Mr. Jeff Lanier, Esq.

The committee held three public meetings at the Capitol complex in Atlanta to hear from the Medical Association of Georgia, the Northeast Georgia Health System, Georgia House Members, emergency room physicians, and insured policyholders regarding the retrospective emergency care payment policies that put Georgia patients at risk. The Committee hoped to hear from representatives from Blue Cross Blue Shield to better understand its policy. Disappointingly, Blue Cross Blue Shield declined the Committee's invitations to each of the three meetings.

During the first committee meeting, members heard from a range of emergency room physicians who discussed the various types of emergency symptoms in the state and the complex issues that face each of them. The committee then focused on policyholders and medical facilities in the second meeting. The following speakers testified before the committee:

September 27th, 2018 — Frank McDonald, M.D. (Georgia Medical Association); John Rogers, M.D.; and D.W. "Chip" Pettigrew, M.D. (Past President, Georgia College of Emergency Physicians).

November 15th, 2018 — Paul Sweatman (Blue Cross/Blue Shield Policyholder); Kara Pugliese (Blue Cross/Blue Shield Policyholder); Jim Hopkins (Blue Cross/Blue Shield Policyholder); and Deb Bailey (Executive Director of Governmental Affairs at Northeast Georgia Medical Center).

December 18th, 2018 — Representative Kim Schofield, 60th District.

Background

On May 19, 2017, Anthem Inc. subsidiary Blue Cross/Blue Shield (BCBS) of Georgia notified policyholders in a letter that starting July 1, 2017, customers would be liable to pay for medical bills for any emergency room (ER) visit found "medically unnecessary" or for a non-emergent

diagnosis. Blue Cross/Blue Shield implemented the same policy in other states including Indiana, Kentucky, Missouri, New Hampshire, and Ohio. Policyholders in these states are now being forced to self-evaluate before making a trip to the emergency room. The question presented to the committee is, "Does this policy violate the Prudent Layperson Standard?"

One of the most vital laws behind medical patient protection is the Prudent Layperson Standard for defining a medical emergency. Georgia law[1] defines "emergency services" or "emergency care" as, "Health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a *prudent layperson*, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

A. Placing the patient's health in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part."

Under federal law[2], "The term emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention..." Following testimony from multiple medical experts and policyholders, the committee presents the following findings to the Georgia House of Representatives.

Committee Findings

From July 2017 through December 2017, about 10,000 emergency room claims were flagged by Anthem, which ultimately denied reimbursement to 3,500 policyholders in Georgia.[3] Anthem's website provides alternatives to emergency room care, but lists "stroke, heart attack, and severe bleeding" as examples of medical conditions for which an ER visit would be acceptable (See Figure 1).[4] Anthem's argument for executing the policy change is policyholders have alternatives to an emergency room when a primary physician is absent, such as telemedicine. Anthem claims its listed non-emergent medical conditions can be treated by urgent care clinics or 24/7 telehealth services. According to Jill Becker, Anthem Spokeswoman, "Anthem sent letters in Missouri and Georgia in an effort to be as transparent as possible about our program to reinforce the certificate language related to appropriate use of the ER."[5]; however, the "Prudent Layperson" standard requires certain insurers to cover services where a rational person without professional or specialized knowledge in medicine would believe their condition to be one of many emergency situations.

[1] Official Code of Georgia Annotated § 33-20A-3.
[2] 45 Code of Federal Regulation 147.138
[3] Office of U.S. Senator Claire McCaskill, "Coverage Denied: Anthem Blue Cross Blue Shield's Emergency Room Initiative, July 2018.
[4] Blue Cross Blue Shield, "Alternatives to Emergency Room Care: Immediate Medical Care: ER or Other Options?" December 2018.
[5] R. Robin McDonald, "Medical Associations Sue Blue Cross Blue Shield, Anthem Over ER Claims," Daily Report, July 2018.

Neither the government nor the courts have given the authority for determining who is a Prudent Layperson to the insurance industry. The skill set of an emergency physician is to identify dangerous symptoms, treat them when they are found, and provide reassurance when symptoms are unrecognized. If illnesses and injuries are left undiscovered due to fear of using health insurance, then it would appear that policyholders do not have insurance coverage at all and have been needlessly paying their premiums. It is a true financial difficulty on each individual and their family to pay the high amount of premiums that enrollees pay on a monthly basis. The committee heard testimony from policyholders who had their emergency room claims delayed, dismissed, or denied. Some policyholders were unaware of their right to appeal any claim rejection from BCBS/Anthem.

Mr. Jim Hopkins gave testimony to the committee members that his son died from a tragic accident on May 10, 2016. [6] The paramedics made the decision to call for a life- flight for his son to be transported to the nearest trauma center in the effort to save his life. BCBS denied all medical claims surrounding the event only three days later. Mr. Hopkins challenged the decision when BCBS denied the emergency room expenses, which were in excess of $150,000. Mr. Hopkins stayed persistent for over five months in his efforts to require BCBS to pay the hospital bills; over six months for the doctors' bills; and over 10 months for the ambulance. After a year of fighting with BCBS and the threat of legal action after all appeals were exhausted, the life-flight claim was finally paid by BCBS.

During the committee hearings, some denials by Blue Cross Blue Shield were found to be surprise billing issues. Although similarly related to the denial of emergency room services, the committee noted public input on the surprise billing concern but understands it to be a separate issue that should be further reviewed.

Anthem's Emergency Room Policy

The committee made several public requests to Blue Cross/Blue Shield of Georgia for an explanation on the logistics of their emergency room payment policies. The only information submitted to the committee members was a copy of an affidavit of John T. Moore, M.D. who gave testimony in the Superior Court of Fulton County involving a court case with Northeast Georgia Health System, Inc., against Blue Cross and Blue Shield of Georgia, Inc., and Anthem, Inc.[7] In Dr. Moore's testimony, he explains how BCBS conducts their "Emergency Department Review" on submitted ER claims:

> "First, the primary diagnosis code listed on the ED (Emergency Department) claim is matched against a list of diagnosis codes that are associated with common non-emergency ailments to determine if the claim merits further review. The codes on the list include conditions that are frequently associated with non-emergency presenting symptoms, and therefore would be better treated by the member's primary care physician or an urgent care clinic. Examples of such conditions include seasonal allergies,

[6] Jim Hopkins, Georgia House Study Committee on Retrospective Emergency Room Policies, November 2018.

[7] John T. Moore, M.D., Superior Court of Fulton County, State of Georgia, " Northeast Georgia Health System, Inc., Northeast Georgia Physicians Group, Inc., and Northeast Georgia Medical Center v. Blue Cross and Blue Shield of Georgia, Inc. and Anthem, Inc." July 2018.

cold symptoms, athlete's foot, sports physicals, and ingrown toenails. If the claim's primary diagnosis is on the list, then the claim will be selected for further review. If not, then the claim is processed and paid under the terms of the Membership Agreement. No claim is denied under the ED Review based solely on the primary diagnosis code that appears on the claim. Instead, the primary diagnosis code is used to identify and filter claims for further review and analysis under the Prudent Layperson Standard.

Second, BCBS Georgia evaluates whether (1) the patient is under 15 years old, (2) the member is directed to the ED by his or her provider, (3) an ambulance claim was billed for the member on the same date of service, (4) the member is traveling out of state, (5) the member receives any kind of surgery, (6) the member receives the services between 8:00 p.m. on a Saturday to 8:00 a.m. on a Monday or on a major holiday, (7) the ED visit is associated with an outpatient or inpatient admission, (8) the member's home address is more than 15 miles from an urgent care center, (9) the member receives an MRI or CT scan, (10) the ED is billed as urgent care, (11) the member receives and electrocardiogram during the visit, or (12) the member receives an MRI or CT scan during the visit. If one of these situations exists, then the claim is processed and paid under the terms of the Membership Agreement.

Third, if none of the above situations exists, then a medical director will determine the member's presenting symptoms and apply the Prudent Layperson Standard. These medical directors are licensed physicians, who are trained to conduct the review from the perspective of a prudent layperson. To conduct this review, BCBS Georgia will always request medical records from the facility that submitted the claim. Information obtained is reviewed by the medical director to determine the member's symptoms and whether the member's ED visit meets the Prudent Layperson Standard. If the medical director determines that a prudent layperson reasonably would believe that he or she was experiencing an emergency medical condition, then the claim is approved and paid under the terms of the Membership Agreement. If the medical director determines that a prudent layperson would not reasonably believe that he or she was experiencing an emergency medical condition, then the services provided in the ED will not be covered. If a claim is denied, the member can appeal the decision. These appeal rights are explained in the Membership Agreement and the written denial letter."

Emergency Room Coverage Denied

Dr. Pettigrew, a retired ER physician, provided testimony to the committee members on some of the illustrations of patients who presented to metro-Atlanta hospitals for emergency services and had their claims denied by Blue Cross/Blue Shield of Georgia.[8] Seventy-five percent of the patients reported were above 40 years of age. All of these cases were denied payment for emergency care by Anthem/BCBS Georgia and were deemed "medically unnecessary":

- **Patient 1:**
  A 64-year-old female is involved in a motor vehicle accident and comes to the ER complaining of very severe neck pain. She has an abnormal exam and receives imaging studies which, though they do not show an acute fracture, do show findings consistent with

[8] D.W. "Chip" Pettigrew, M.D., Georgia House Study Committee on Retrospective Emergency Room Policies, September 27, 2018.

severe muscle spasm (her neck's curvature has been reversed due to muscle spasm). She is diagnosed and treated for an acute neck strain. Payment denied. Services not deemed a "medical necessity" by Anthem/BCBS.

- **Patient 2:**
  A 62-year-old male has an uncontrolled nose bleed where compression is not working. He is on anticoagulants, which make his nosebleed potentially life-threatening if it's not quickly and correctly controlled. In the ER, aggressive treatment is initiated and he is admitted to the hospital by the surgeon for further control and monitoring. Payment denied. Services not deemed necessary.
- **Patient 3:**
  A 59-year-old male fell and sustained a large laceration on his head. His scalp is repaired emergently in the ER. Payment denied. Services not deemed necessary.
- **Patient 4:**
  A 52-year-old female has increasing chest pain and shortness of breath. She has a history of angina and had been recently admitted to the hospital for heart disease. She is stabilized in the ER and transferred for admission to her doctor's hospital for further stabilization and treatment. This ER visit was on a weekend. Payment denied. Services deemed unnecessary despite this visit being on a weekend, which is a documented exclusion to BCBS policy.
- **Patient 5:**
  A 21-year-old female with Sickle Cell Disease in severe pain/ischemia crisis (a life-threatening condition) visits the emergency room. She was aggressively treated, stabilized and admitted to the hospital for further treatment. Payment denied. Services not deemed necessary.
- **Patient 6:**
  A 43-year-old female with a history of prior clots in her lungs developed calf pain and shortness of breath a few weeks after undergoing surgery. She is emergently and thoroughly evaluated, but no evidence of a clot is found and she is, gratefully, discharged. Payment denied. Services not deemed necessary.
- **Patient 7:**
  A 34-year-old male falls off a hoverboard and has a sudden onset of pain in his wrist. He is evaluated in the ER and found to have a fracture of his wrist. He has a cast applied and is discharged for follow up with an orthopedic doctor. Payment denied. Services not deemed necessary.
- **Patient 8:**
  A 46-year-old female comes to the ER complaining of severe abdominal pain. She has a complex medical history of various significant diseases (diabetes, hypertension, heart failure, cancer, kidney disease, etc.) During her evaluation, she is found to have a serious liver abnormality. She is stabilized for further outpatient evaluation. Payment denied. Services not deemed necessary.
- **Patient 9:**
  A 45-year-old male comes to the ER requesting help. It is discovered that he is actually in advanced stages of acute alcohol withdrawal (which has high mortality if untreated) and is appropriately treated. Payment denied. Services not deemed necessary.
- **Patient 10:**
  A 38-year-old male comes to the ER in the early morning hours with a laceration to his foot after he had dropped a knife on it at home. He has a significant laceration which

requires immediate cleaning and suture closure. Payment denied. Services not deemed necessary.

- **Patient 11:**
  A 52-year-old female complains of chest pain. She checks her blood pressure and calls her private doctor who tells her to go to the ER for an evaluation. She has a thorough workup and is stabilized for discharge and further evaluation by her private doctor. Payment denied. Services not deemed necessary.
- **Patient 12:**
  A 50-year-old female comes to the ER during the early morning hours complaining of domestic abuse and subsequent arm pain. She is treated for a fracture of her wrist and a police report is made. She is safely discharged to the care of supportive family members. Payment denied. Services not deemed necessary.

Transparency

The committee made several requests to Blue Cross Blue Shield of Georgia including requesting the policies and procedures at issue, list of billing codes related to symptoms that would never be considered an emergency, and data on the percent of claims and appeals that do not receive approval or payment of services rendered. The requested information was not provided. Additionally, as previously indicated, an invitation was extended to Georgia Blue Cross Blue Shield for all three meetings, and each of those invitations was declined.

As a result of Georgia Blue Cross Blue Shield's refusal to provide information and refusal to provide testimony, the committee also sought information via an open records request to the Georgia Office of the Commissioner of Insurance seeking a copy of Blue Cross Blue Shield/Anthem's ER policy. This open records request was denied based on an affidavit submitted to the committee claiming the contents of Anthem's policy as proprietary information (See Figure 2).[9] At best, Blue Cross Blue Shield's lack of transparency and failure to engage with the committee was disappointing; at worst, it was obstructionist and disrespectful to the House of Representative's desire to study retroactive emergency room policies.

Conclusion

Affordability is the most common argument for a reduction in medical coverage by the health insurance industry; however, the White House's Council of Economic Advisers released a report stating that between the years 2014-2018, "the stock prices on health insurance companies rose by 272 percent." (See Figure 3)[10] Aggressive actions by insurance companies to deny emergency room services threatens the health of policy members in Georgia. Commercially-insured patients pay enough in copayments and coinsurance for an emergency room visit. Some patients still pay a large out-of-pocket cost for a life-threatening emergency.

According to the Kaiser Family Foundation, the average annual premiums for employer-sponsored health insurance in 2018 were $6,896 for single coverage and $19,616 for family coverage.[11] These

[9] Affidavit of Jeff Fusile, President Blue Cross Blue Shield of Georgia, submitted by Georgia Office of Insurance and Safety Fire Commissioner to Rep. David Knight, September 2018.
[10] The Council of Economic Advisers (2018), "The Profitability of Health Insurance Companies," March 2018.
[11] Henry J. Kaiser Foundation, "2018 Employer Health Benefits Survey," Oct. 2018. https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/

averages show that over the past decade, family premiums have escalated faster than the rate of worker's earnings and inflation combined. This data also shows that deductibles have increased eight times faster than wages (See Figure 4). About 152 million Americans depend on employer-sponsored coverage which covers over half of the non-elderly population.[12] There is little evidence showing a reasonable connection between preventing emergency room claims by reviewing a final diagnosis.[13] The state and federal Prudent Layperson Standard must remain applicable to cover emergency care without prior authorization.

Patients with true emergencies have similar symptoms to those patients that have non-emergent conditions. Experienced medical physicians may have difficulty determining if a condition or symptom is a true emergency without conducting a general examination; however, Blue Cross Blue Shield of Georgia/Anthem uses the same medical examination results to determine if a policyholder's medical care is non-emergent. This policy is dangerous to many Georgians who purchased a medical insurance plan in good faith, and later face the financial burdens of medical bills and devastating complexity of Anthem's requirements for reconsideration.

When a medical insurance company refuses or reduces payment for a medical condition that is determined non-emergent retrospectively, the direct burden not only falls on the policyholder but on the facilities and medical providers involved. Anthem is forcing patients to perform as medical experts when they experience unintended medical events. More diligent and prudent assessment should take place during any claims determination process. The Georgia Hospital Association submitted comments on Retrospective Emergency Room Policies and provided testimony that when Blue Cross Blue Shield of Georgia implemented its non-emergent ER policy they, "…advised hospitals to bill the full charge to patients if claims were denied."[14] Hospitals do have options to provide charity care, but often times the cost of care must be absorbed because reimbursement is not provided.

Georgia legislators should consider responses to harmful ER policies and the challenges outlined in this report to prevent patients from unfairly carrying the costs of emergency medical services. The committee questions the motives of an insurance company when services are not deemed medically necessary, but the consumer is burdened with the full cost of an emergency room bill. Furthermore, a denied benefit by the insurance company makes the out of pocket emergency room bill ineligible to be applied to a health plans deductible. The committee also questions if there is a proper mechanism for accountability and oversight in Georgia law to uphold the Prudent Layperson Standard. Finally, the committee believes the course of conduct by Blue Cross Blue Shield of Georgia in connection with this committee's charge is cause for grave concern. Blue Cross Blue Shield of Georgia together with its affiliates, administers benefits for state health benefit patients, state Medicaid patients, and commercial patients. Moving forward, careful scrutiny of the practices of Blue Cross Blue Shield of Georgia and its affiliates is warranted by this body, as well as state agencies with whom they contract.

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[12] Kaiser Commission on Medicaid and the Uninsured, "The uninsured: A primer – Key facts about health insurance and the uninsured in the era of health reform," Dec. 2017. http://files.kff.org/attachment/Supplemental-Tables-The-Uninsured-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-Under-the-Affordable-Care-Act.

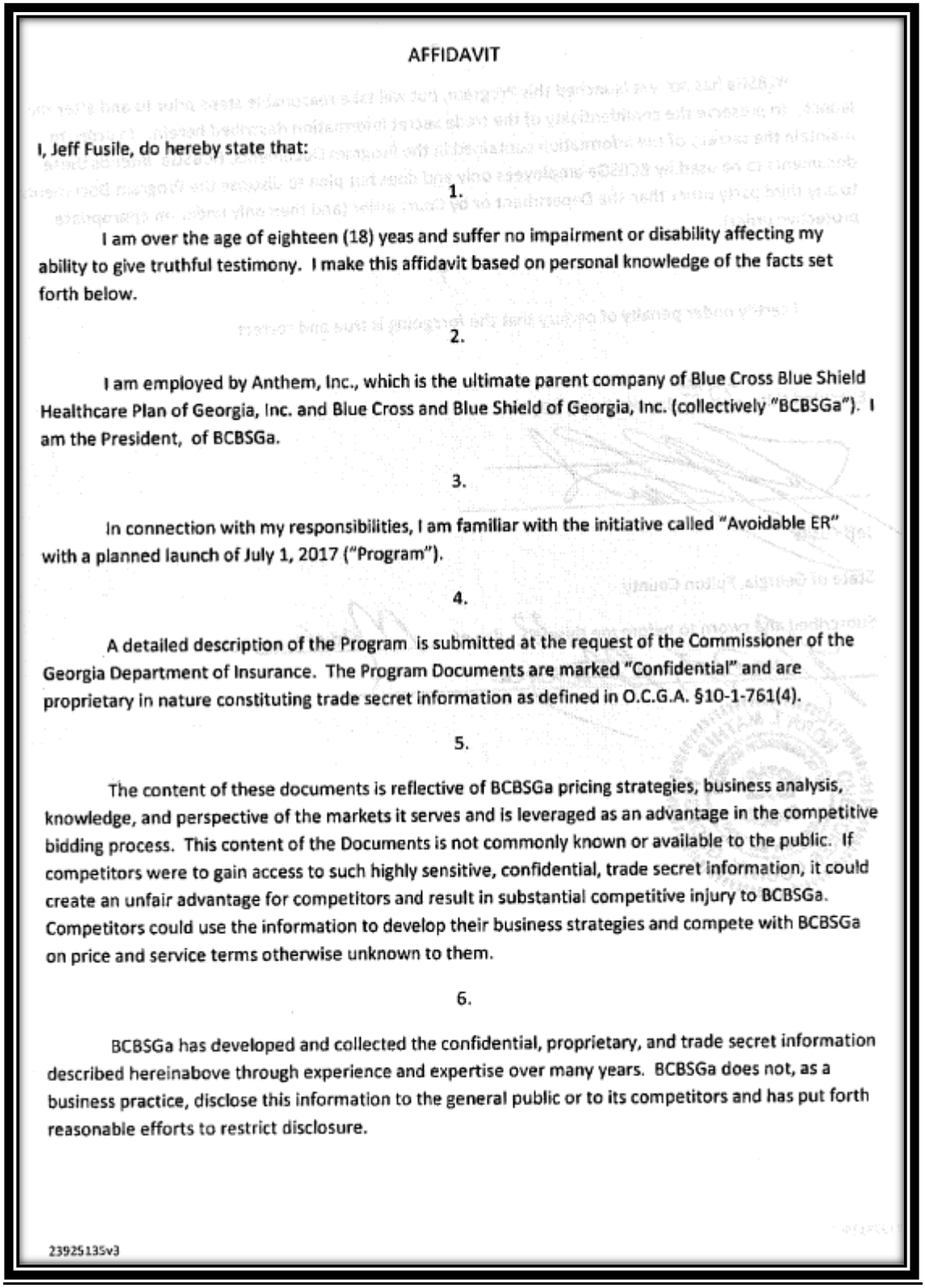
[13] MC Raven, RA Lowe, J Maselli, et. al, "Comparison of Presenting Complaint vs. Discharge Diagnosis for Identifying 'Nonemergency' Emergency Department Visits." JAMA. 2013; 309(11): 1145-1153.

[14] Letter from Donna S. Hatchet, Vice President, Managed Care Policy, Georgia Hospital Association, to Rep. David Knight, December 2018.

Figure 1.

	Retail Health Clinic	Walk-in Doctor's Office	Urgent Care Center	Emergency Room
Animal bites			✓	▪ Sudden or unexplained loss of consciousness ▪ Signs of a heart attack, such as sudden/severe chest pain or pressure ▪ Signs for a stroke, such as numbness of the face, arm or leg on one side of the body; difficulty talking; sudden loss of vision ▪ Severe shortness of breath ▪ High fever with stiff neck, mental confusion and/or difficulty breathing ▪ Coughing up or vomiting blood ▪ Cut or wound that won't stop bleeding ▪ Possible broken bones ▪ Poisoning ▪ Stab wounds ▪ Sudden, severe abdominal pain ▪ Trauma to the head ▪ Suicidal feelings ▪ Partial or total amputation of a limb
Stitches			✓	
X-ray			✓	
Back pain		✓	✓	
Mild asthma		✓	✓	
Minor headache		✓	✓	
Sprain, strain		✓	✓	
Nausea, vomiting, diarrhea		✓	✓	
Bumps, cuts, scrapes	✓	✓	✓	
Burning with urination	✓	✓	✓	
Cough, sore throat	✓	✓	✓	
Ear or sinus pain	✓	✓	✓	
Eye swelling, irritation, redness or pain	✓	✓	✓	
Minor allergic reaction	✓	✓	✓	
Minor fever, colds	✓	✓	✓	
Rash, minor bumps	✓	✓	✓	
Vaccination	✓	✓	✓	

Figure 2.



AFFIDAVIT

I, Jeff Fusile, do hereby state that:

1.

I am over the age of eighteen (18) yeas and suffer no impairment or disability affecting my ability to give truthful testimony. I make this affidavit based on personal knowledge of the facts set forth below.

2.

I am employed by Anthem, Inc., which is the ultimate parent company of Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Blue Cross and Blue Shield of Georgia, Inc. (collectively "BCBSGa"). I am the President, of BCBSGa.

3.

In connection with my responsibilities, I am familiar with the initiative called "Avoidable ER" with a planned launch of July 1, 2017 ("Program").

4.

A detailed description of the Program is submitted at the request of the Commissioner of the Georgia Department of Insurance. The Program Documents are marked "Confidential" and are proprietary in nature constituting trade secret information as defined in O.C.G.A. §10-1-761(4).

5.

The content of these documents is reflective of BCBSGa pricing strategies, business analysis, knowledge, and perspective of the markets it serves and is leveraged as an advantage in the competitive bidding process. This content of the Documents is not commonly known or available to the public. If competitors were to gain access to such highly sensitive, confidential, trade secret information, it could create an unfair advantage for competitors and result in substantial competitive injury to BCBSGa. Competitors could use the information to develop their business strategies and compete with BCBSGa on price and service terms otherwise unknown to them.

6.

BCBSGa has developed and collected the confidential, proprietary, and trade secret information described hereinabove through experience and expertise over many years. BCBSGa does not, as a business practice, disclose this information to the general public or to its competitors and has put forth reasonable efforts to restrict disclosure.

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7.

BCBSGa has not yet launched this Program, but will take reasonable steps prior to and after the launch, to preserve the confidentiality of the trade secret information described herein. In order to maintain the secrecy of the information contained in the Program Documents, BCBSGa intends these documents to be used by BCBSGa employees only and does not plan to disclose the Program Documents to any third party other than the Department or by Court order (and then only under an appropriate protective order).

7.

I certify under penalty of perjury that the foregoing is true and correct.

Executed this 22ND day of March, 2017

Jeff Fusile

State of Georgia, Fulton County

Subscribed and sworn to before me this 22 day of March, 2017

NORA L MATHIS NOTARY PUBLIC CHEROKEE COUNTY, GEORGIA MY COMMISSION EXPIRES JANUARY 24, 2020

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Figure 3. **Health Insurance Stock Index vs. Benchmarks**

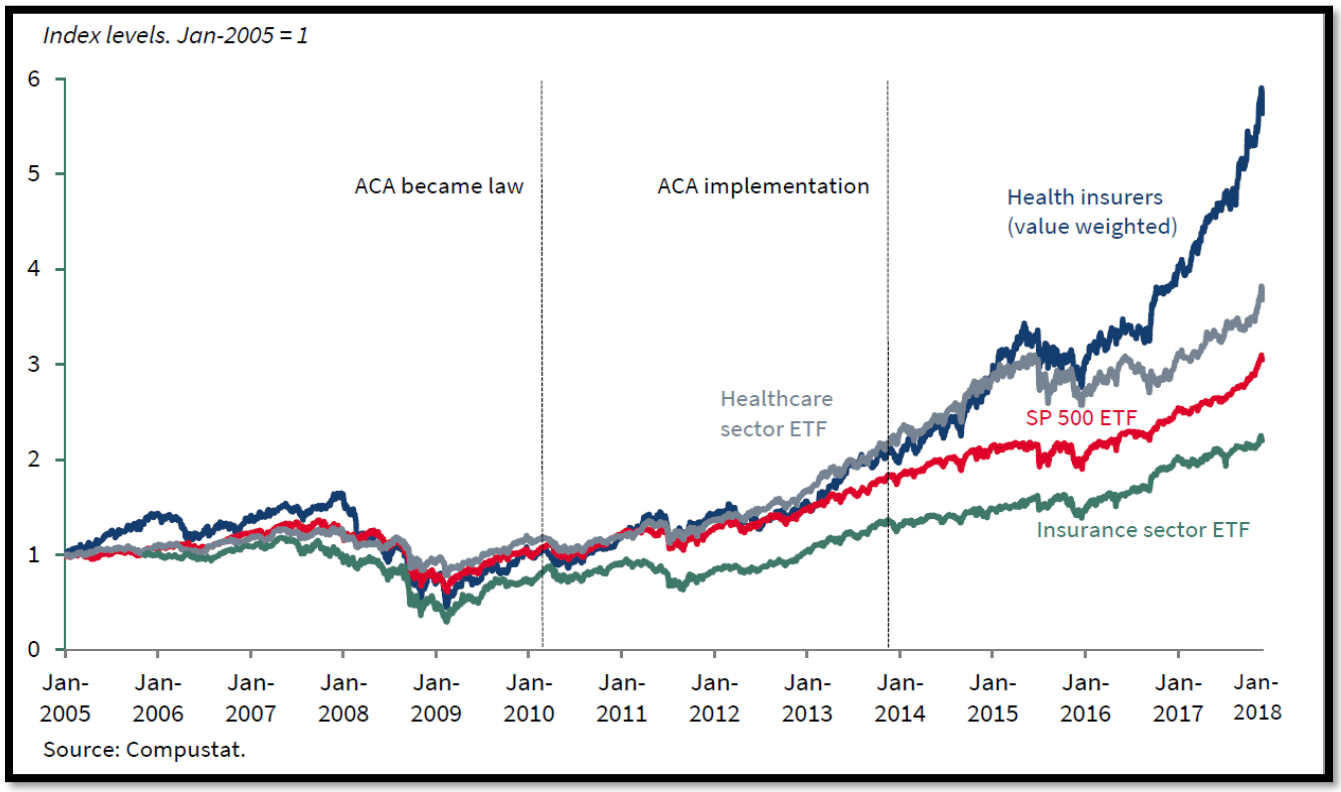

Figure 4.